

METHOD OF ADMINISTERING A HEALTH PLAN

BACKGROUND OF THE INVENTION

[0001] This invention relates to a method of administering health plans, and in particular to methods of compensating groups of physicians for providing medical services to patients belonging to a health plan.

[0002] There are various methods of administering health plans to take into account the goals of providing quality health services with high patient satisfaction while controlling costs. One type of health plan structure is a health maintenance organization (HMO) which offers prepaid, comprehensive health coverage for both hospital and physician services. An HMO contracts with health services providers, e.g., physicians, hospitals, and other health professionals, and members are required to use participating providers for all health services if they want the services to be covered by the plan. Members are enrolled for a specified period of time. Model types include staff, group practice, network and IPA. A common way of compensating primary care physicians (PCPs) in an HMO plan is based on capitation -- a method of payment in which the provider is paid a fixed amount for each member who selects the physician as their PCP no matter what the actual number or nature of services delivered by the PCP. Another type of health plan structure is the preferred provider organization (PPO) which is a combination of hospitals and physicians that agrees to render particular services to a group of people under contract with an insurer. The services are commonly furnished at discounted rates and the insured population may incur out-of-pocket expenses for covered services received inside or outside of the PPO. The physicians are typically compensated a discounted fee based on services actually provided.

[0003] The problem with existing health plan structures has been to provide appropriate incentives for physician decision makers in the health services process to control costs without sacrificing the quality of health care or patient satisfaction. The incentives may apply to the whole health care process, and not merely to individual services.

SUMMARY OF THE INVENTION

[0004] The method of the present invention recognizes that physicians are the health services experts and represent the ultimate key to reducing a health plan's total medical costs.

Physicians are in the best position to manage health costs, and can manage health costs more effectively, and work most efficiently on behalf of patient's health needs in a group practice environment. The method also recognizes that physicians provided with accurate utilization data on a timely basis will make better decisions.

[0005] Generally, in accordance with the principles of the present invention, contracts are made between the health plan and groups of physicians to provide health services to members of the health plan. The method comprises a way of compensating physician groups that provides appropriate incentives to control costs, while maintaining quality of care and/or patient satisfaction. Groups of physicians are entitled to share in cost savings compared to the group's past experience which is represented in the form of an annual budget. Eligibility for sharing in cost savings is dependent upon the group's first achieving certain quality and patient satisfaction goals, and preferably the size of the share depends upon the level of quality and patient satisfaction achieved by the group. The size of the share preferably also depends upon the relative cost performance of the group compared to other physicians in the applicable medical specialty in the network.

[0006] Generally, the method of compensating physician groups that are part of a network providing health services to patients comprises determining an unadjusted final budget based upon the group's historical cost experience; determining goals for medical specialty specific quality indicators for the group is based upon the applicable medical specialty network's prior scores for those indicators; determining goals for patient satisfaction indicators for the group based upon a network's (or a portion of a network's) prior scores for those indicators; providing data to the group and the individual physicians in the group, regarding utilization and quality results; finalizing the group's unadjusted final budget by case mix adjusting to the group's actual case mix and trending the budget for inflation; awarding additional compensation to the group if there is a positive variance between the finalized budget and the actual cost. Additional compensation is preferably based on the group's performance relative to other applicable medical specialty physicians and is preferably dependant upon achieving certain measures of quality and patient satisfaction.

BRIEF DESCRIPTION OF THE DRAWINGS

[0007] Fig. 1 is a sample Budget vs. Actual Interim Report, comparing the group's actual TACClessRx to the casemix adjusted budget and broken out in the major categories of, Professional, Facility, Other, and Outpatient Drug;

[0008] Fig. 2 is a sample Network vs. Actual Interim Report comparing the group's actual TACClessRx to the casemix adjusted applicable medical specialty network, and broken out in the major categories of Professional, Facility, Other and Outpatient Drug;

[0009] Fig. 3 is a sample Group PTE Profile with Network Comparison, comparing PTE Equivalents, Case Mix, and TACClessRx for a group and the network;

[0010] Fig. 4 is a sample Physician PTE Profile showing PTE description, PTE equivalents, Case Mix, and TACClessRx including Professional, Facility, Drug and other costs;

[0011] Fig. 5 is a sample Physician PTE by Cost Categories, showing Professional Services charges, Facility Charges, and other charges by Physician, Group, Variance, Specialty Network, and Variance;

[0012] Fig. 6 is a sample PTE Detail Utilization – Inpatient report;

[0013] Fig. 7 is a sample PTE Detail Utilization – Outpatient report;

[0014] Fig. 8 is a sample Physician Quality Indicator Member Detail report;

[0015] Fig. 9 is a sample Annual Reconciliation Report;

[0016] Fig. 10 is a sample Group Quality Indicator Summary report;

[0017] Fig. 11 is a sample Patient Satisfaction Survey Results – Group report;

[0018] Fig. 12 is a sample Patient Satisfaction Survey Results – Physician report;

[0019] Fig. 13 is a sample Patient Satisfaction Survey Age/Sex Breakdown – Group report;

[0020] Fig. 14 is a sample Patient Satisfaction Survey Age/Sex Breakdown – Physician;

[0021] Fig. 15 is a sample Annual Performance Measures report;

[0022] Fig. 16 is a sample Subsequent Year Budget Detail report;

[0023] Fig. 17 is a sample Subsequent Year Budget report;

[0024] Fig. 18 is a sample Medical Cost Trend Comparison report;

[0025] Fig. 19 is a sample Program Specialist Model Aggregate Medical Cost Trend Compared to non-Program Network report;

[0026] Fig. 20 is a sample Full Network Detail Report by Physician;

[0027] Fig. 21 is a sample Non-Program Specialty Network Average Report by Region and Specialty;

[0028] Fig. 22 is a sample Program Specialty Network Average Report by Region and Specialty;

[0029] Fig. 23 is a sample Full Specialty Network Average Report by Region and Specialty

[0030] Fig. 24 is a sample Non-Program Network Summary Report by Specialty;

[0031] Fig. 25 is a sample Program Network Summary Report by Specialty; and

[0032] Fig. 26 is a sample Full Network Summary Report by Specialty;

[0033] Fig. 27 is a sample Budget-Final Unadjusted report;

[0034] Fig. 28 is a sample Group PTE Profile report;

[0035] Fig. 29 is a sample Physician Ranking report;

[0036] Fig. 30 is a sample Physician PTE Summary report;

[0037] Fig. 31 is a sample Program Specialist Model Reporting of Fee for Service Payments by Physician Report; and

[0038] Fig. 32 is an illustration of a patient satisfaction survey of the type that may be employed in conjunction with the methods of the present invention.

DETAILED DESCRIPTION OF THE PREFERRED EMBODIMENT

[0039] Recognizing that the physician is often in the best position to balance the appropriateness of medical care with the cost of providing that care, and that physicians often make better decisions in this regard when they are acting as part of a group, the method of this invention provides a way of managing the provision of health care to members of a health plan that provides incentives to groups of physicians for achieving cost savings, but only if certain quality and patient satisfaction levels are first achieved.

[0040] According to the principles of this invention, a budget is prepared for a physician group based upon the physician group's actual past experience. The budget is comprised of patient treatment episodes (PTE'S), which include all of the downstream medical care costs incurred in diagnosing and/or treating a particular disease or medical condition (or at least the covered costs for the disease or condition), during a specific episode (time period) of care.

[0041] The PTE preferably includes all services and treatments performed until the illness or condition is abated. There are two types of PTE's: chronic PTE's, which include all the services and treatments for a chronic condition that does not abate, and acute PTE's which include all services and treatments for an illness or medical condition that ends or abates. A PTE includes services that are not necessarily typical, but address the same condition as the core procedure or complications of the core procedure. It may include radiology and diagnostic services that deal with the same body system or medical condition as the core procedure, pathology and lab services that are typically performed in relation to the core procedure or underlying condition, and evaluation and management services.

[0042] Each PTE is initiated by a claim for treatment related to a particular disease or condition, and continues until there is a break or gap in claims related to that disease or condition equal to a predetermined window period. The window period varies from PTE to PTE depending upon the disease or condition to which the PTE relates. The diseases and conditions that start a PTE and the window period for PTE's relating to the diseases or conditions can be developed by the health plan, or one of many health care software companies. Data from claims is processed and collected in one or more PTE's for each patient based upon the disease or condition that caused the patient to seek treatment. One organization that processes claims data into PTE's is Express Scripts, Inc., Data Integration Division (ESDID) a wholly owned division of Express

Scripts, Inc., of St. Louis, Missouri. ESDID has identified more than 1100 diagnostic clusters based upon the International Classification of Disease (9th Edition), commonly referred to as ICD-9, developed in conjunction with the World Health Organization, and well known in the health care industry and incorporated herein by reference. Other well known schemes for organizing diseases and conditions in diagnostic clusters include Schneeweiss and Rosenblatt's, Diagnostic Clusters (1983), J. Gonella, Disease Staging (1986), and Rand's Longitudinal Episode Definitions (1985), all of which are incorporated herein by reference. Still another scheme is American Medical Association's CPT-4, also incorporated herein by reference. These schemes could be used directly or adapted for use in identifying and managing PTE's, by grouping the codes into meaningful groups or diagnostic clusters, based upon clinical homogeneity with respect to generating a similar clinical response from physicians, reducing the effect of idiosyncratic diagnosis coding patterns. PTE's generally allow for the analysis of medical services on a complete course of treatment basis, rather than on an incident by incident basis.

[0043] As described above, each PTE has a window period associated with it, which depends upon the disease or condition to which the PTE relates. This window period is based upon the maximum number of days between contact with a health services provider for which follow-up care is still reasonable. This provides a clinically valid approach because the patient's episode duration relates directly to their process of care. This allows condition-specific practice patterns to be developed for each physician. Each diagnostic cluster has its own unique window period. When there is a gap or break in claims for medical services that exceeds the window period, the PTE ends, and future claims, even for the exact same disease or condition, mark the start of a new PTE. It is possible that a single patient could simultaneously have multiple PTE's. As described above particularly with respect to chronic PTE's, it is further possible that PTE do not end but rather continue from year to year.

[0044] The PTE is associated with the physician and thus the physician group that is the source for the largest amount of the professional claims. Thus when several physicians are involved in treating the patient for a particular disease or condition, the PTE related to that disease or condition is associated with the physician responsible for the most professional charges.

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[0045] The program is preferably implemented with ten target specialties: Internal Medicine/Family Practice, Pediatrics, Obstetrics/Gynecology, Cardiology, Orthopedics, General Surgery, Gastroenterology, Urology, Otolaryngology, Ophthalmology, although fewer, more, or different specialties could be used.

[0046] According to a program implementing the method of this invention, a budgeted total average covered charge less drug (TACClessRx) is developed for each participating physician group preferably based upon the past experience of the physicians in the group. While the program is open to any group of physicians, to qualify for the performance based additional compensation that is a significant feature of this program, the group should average at least a minimum level of past experience. Thus in the preferred embodiment, the average number of PTE's per physician in a group should meet or exceed a predetermined threshold before the group can participate in the performance based additional compensation feature of the program. Furthermore, the threshold may vary from group to group, depending upon the particular medical specialty of the group. Table 1 shows a minimum average level of experience for various specialties that might be used to implement the methods of this invention. In a network using the minimums set forth in Table 1, the average level of experience of the physicians in a group must exceed the minimum in the table, or the group cannot participate in the performance based additional compensation.

Table 1 Minimum Experience to Participate	
Specialty	Average Number of PTEs Per Physician
OB/GYN	5
Pediatrics	2
Orthopedics	4
General Surgery	1
Cardiology	1
Urology	8
Ophthalmology	3
Gastroenterology	5
Otolaryngology	6
Family/General Practice	2
Internal Medicine	2

Example 1

[0047] A OB/GYN group of five physicians has the following experience: Physician A - 4 PTE's, Physician B - 0 PTE's, Physician C - 10 PTE's, Physician D - 5 PTE's and Physician E - 6 PTE's. The average level of experience is 25 PTE's/ 5 or 5 PTE's per physician. This group equals the minimum average experience level, and can participate in the performance based compensation feature of the program. As explained in more detail below, according to Table 2, 25% of this group's experience would be used and 75% of the applicable network experience would be used. Even if the group could not participate in the performance-based additional compensation feature, program participation is valuable to the group because it provides various reporting information about the group and its performance relative to other groups.

[0048] The budget for the group is determined based at least in part on the group's historic (e.g., last twelve month) performance. Preferably, there is a weighted application of the group's historic performance and the network's historic performance over the same period. The inventors have determined that the weighting factor for the group's historic performance preferably depends upon the particular medical specialty of the group. Table 2 is an example of a possible scheme for weighting a group's historic performance based upon the average number of PTE's per physician prior to joining the program:

Table 2
Credibility Factor to Apply to Specialist Group's Own Experience

	25%	35%	45%	55%	65%	75%	85%	90% - 100%
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OB/GYN	5	9	12	18	27	44	85	137
Pediatrics	2	3	5	7	10	17	32	54
Orthopedics	4	6	8	13	19	30	58	93
General Surgery	1	2	3	4	6	10	17	28
Cardiology	1	2	3	4	6	10	17	28
Urology	8	13	20	30	46	73	135	181
Ophthalmology	3	4	6	10	15	24	45	72
Gastroenterology	5	6	8	12	27	43	78	122
Otolaryngology	6	9	13	20	30	50	93	146
Family Practice	2	3	5	7	10	18	32	54
Internal Medicine	2	3	5	7	10	18	32	54

Example 2 illustrates the application of the credibility factor to determining the first year's budget.

Example 2

[0049] An OB/GYN group has an average of 21 PTE's/physician in the year prior to joining the program. In the OB/GYN category (row 1 in Table2), 21 is closest to "18", which corresponds to the 55% credibility factor. This means that the group's own experience is given 55% weight, and the applicable medical specialty network's overall experience for that specialty is given 45% weight (100% - 55%).

[0050] The number of physicians that receive 100% credibility for their historical experience is a matter of statistical analysis. For most specialties, the percentage of physicians receiving 100% credibility for their past experience should be less than 50%, and this can be adjusted by adjusting the average number of PTE's required for each credibility level. Table 3 illustrates one possible arrangement for the percentage of physicians receiving 100% credibility of past experience in the various specialties in Table 2:

Table 3 % of Physician Groups Receiving 100% Credibility	
OB/GYN	20%
Pediatrics	55%
Orthopedics	20%
General Surgery	30%
Cardiology	35%
Urology	1%
Ophthalmology	25%
Gastroenterology	10%
Otolaryngology	20%
Family Practice	38%
Internal Medicine	38%

[0051] Once the group's budget is determined, the physicians in the group perform health services during the year. Statistics regarding the number of PTE's, the TACClessRx of the group, and of other groups in the network are collected and distributed. These reports provide valuable utilization and measure performance information and may enable the physicians in the groups to better manage their patient's health needs. Fig. 1 is a sample Budget vs. Actual Interim Report showing TACClessRx, Professional, Facility, Other, and Outpatient Drug. Fig. 2 is a sample Network vs. Actual Interim Report, showing TACClessRx, Professional Facility, Other, and Outpatient Drug. Fig. 3 is a sample Group PTE Profile with Network Comparison, comparing PTE Equivalents, Case Mix, and TACClessRx for a group and the network. Fig. 4 is a sample Physician PTE Profile showing PTE description, PTE equivalents, Case Mix, and TACClessRx including Total, Professional, Facility, Drug and other costs. Fig. 5 is a sample Physician PTE by Cost Categories, showing Professional Services charges, Facility Charges, and other charges by Physician, Group, Variance, Specialty Network, and Variance. Fig. 6 is a sample PTE Detail Utilization-Inpatient Report. Fig. 7 is a sample PTE Detail Utilization-Outpatient Report.

[0052] Claims for health services are paid by the health plan as they normally would be.

[0053] As discussed above, a group must meet minimum quality and patient satisfaction goals to be eligible for additional compensation. The initial criteria shaping the selection of quality and patient satisfaction measures should draw on well-known surveys and scoring methodologies, and the thresholds should be reasonable. There are a variety of third-party organization that have or may in the future publish objective quality indicators, for example Health Employer Data Information Set (HEDIS), American Accreditation Health Care Commission Utilization Review Accreditation Committee (URAC) or National Committee for Quality Assurance (NCQA). These have the advantage of having nationally validated scoring algorithms available. Alternatively, quality indicators can be developed by the health plan implementing the program, preferably in consultation with the participating physicians. One type of quality indicators that can be established is percentages of patients that receive or do not receive particular treatments.

[0054] Further specificity – there are PTE based and frequency based indicators. PTE based indicators are indicators directly associated with a diagnosis. Frequency based indicators pertain to the rate of specific procedures or preventative screening.

[0055] These types of indicators are shown in Table 4:

Table 4
Quality Indicators by Specialty

	Specialty Network Actual	Standard Deviation	Low	High	0%	9%	12%	15%
Cardiology								
Congestive heart failure with ACE/ARBs	70%	7.84	62.20%	77.90%	<62%	62% -78%	78% <86%	86%
Congestive heart failure with Beta Blocker	51.10%	8.56%	42.50%	59.70%	<43%	43% -60%	60% <69%	69%
CABG	2.20%	0.66%	1.50%	2.80%	>3%	1.5% -3%	1.5% >0.8%	0.8%
Internal Medicine								
Diabetes with ACE/ARB	32.50%	3.38%	29.10%	35.80%	<29%	29% -36%	36% <39%	39%
Ischemic heart disease with beta blockers	44.70%	3.91%	40.80%	48.60%	<41%	41% -49%	49% <53%	53%
Congestive heart failure with ACE	73.70%	8.15%	65.60%	81.90%	<66%	66% -82%	82% < 90%	90%
Pediatrics								
First line Antibiotics	67.40%	1.05%	66.30%	68.40%	< 66%	66% -68%	68% < 69%	69%
DTP immunization	88.90%	2.24%	86.70%	91.20%	< 87%	87% -91%	91% <93%	93%
Orthopedics								
Laminectomy	1.40%	.28%	1.10%	1.70%	> 2%	1% -2%	<1% >0.8%	0.8%
Knee Arthroscopy	6.20%	0.57%	5.70%	6.80%	> 7%	6% -7%	<6% >5%	5%
Carpal Tunnel	0.90%	0.25%	0.70%	1.10%	> 1%	0.7% -1%	<0.7% >0.5%	0.5%
Shoulder Surgery	2.50%	0.37%	2.20%	2.90%	> 3%	2% - 3%	< 2% > 1.8%	1.8%
OB/GYN								
Hysterectomy	2.60%	0.24%	2.30%	2.80%	> 3%	2% -3%	< 2% > 1.8%	1.8%
Breast Cancer Screening	70.40%	1%	69.40%	71.40%	< 69%	69% -71%	71% < 72%	72%
Cervical Cancer Screening	76.80%	0.79%	43%	77.60%	< 76%	76% -78%	78% < 72%	79%
HRT	44.20%	1.30%	42.90%	45.50%	< 43%	43% -46%	46% < 47%	47%
General Surgery								
Cholecystitis with lap Cholecystectomy	83.20%	3.93%	79.30%	87.1	< 79%	79% - 87%	87% < 91%	91%
Needle localization for breast biopsy	23.40%	2.54%	20 90%	25.9	< 21%	21% - 26%	26% < 27%	27%
ENT								
Myringotomy	23.90%	2.46%	21.40%	26.30%	> 26%	21% - 26%	21% > 19%	19%
Tonsillectomy	9.80%	1.71%	8.10%	11.50%	> 12%	8% - 12%	< 8% > 6%	6%
Endoscopic sinus surgery	3.70%	0.64%	3.10%	4.40%	> 4%	3% - 4%	< 3% - >2%	2%
Urology								
Prostatectomy	3.90%	1.18%	2.70%	5.10%	> 5%	3% - 5%	< 3% > 1.5%	1.5%
Prostatic hyperplasia with prostate surg	3.10%	1.74%	1.30%	4.80%	> 5%	1% - 5%	< 1% > 0.8%	0.8%
GI								
PUD with endoscopy	71 30%	9.53%	61 80%	80.90%	> 81%	62% - 81%	62% > 52%	52%
Patients with endoscopy	21.10%	1.73%	19.40%	22.80%	> 23%	19% - 23%	19% > 18%	18%
Opthamology								
Cataract surgery	3.30%	0.63%	2.70%	3.90%	> 4%	3% - 4%	<3% > 2%	2%

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[0061] At the end of the contract year the actual cost performance is compared to the budgeted cost performance. The budget is adjusted upwardly or downwardly to account for changes in the actual mix of cases, *e.g.*, increases and decreases in the severity of the illnesses of the patients seen. A casemix factor is determined by summing the Relative Value Units (RVUs) for each full or partial PTE, and dividing this sum by the total number of full and partial PTE's or PTE equivalents. The RVU is a measure of case complexity based upon resource consumption, comparable to the resource-based relative value scale (RBRVS) used in the Medicare program. The RVU assigns a relative value to all diagnostic clusters for each level of severity of illness, and facilitates comparison of expected resource usage across different severity of illness levels, and may also account for different ages/genders. Any system of assigning relative values to PTE's caused by different diseases and conditions, that takes into account the different resources employed, can be used. The Casemix factor is calculated for both the budget year and the actual performance year and the $\text{Adjustment}_{\text{casemix}}$ is the $\text{Casemix}_{\text{performance year}}$ divided by the $\text{Casemix}_{\text{budget year}}$. The TACClessRx for the budget year ($\text{TACClessRx}_{\text{budget year}}$) is then adjusted to allow a comparison that takes into account the severity of the illnesses treated each year. This is illustrated in Example 3.

Example 3

[0062] According to the budget developed at the start of the program year, a group was predicted to have a total of 3,472 full and partial PTE's (PTE equivalents), a $\text{Casemix}_{\text{budget year}}$ of 1.2822, and a $\text{TACClessRx}_{\text{budget year}}$ of \$981.91, while the actual performance resulted in 3,588 full and partial PTE's, a $\text{Casemix}_{\text{performance year}}$ of 1.2803, and a $\text{TACClessRx}_{\text{performance year}}$ of \$1074.17. The $\text{Adjustment}_{\text{casemix}}$ is $\text{Casemix}_{\text{performance year}} / \text{Casemix}_{\text{budget year}}$ $1.2803 / 1.2822 = 0.9985$. The Adjusted $\text{TACClessRx}_{\text{budget year}}$ is therefore $\text{TACClessRx}_{\text{budget year}}$ multiplied by the $\text{Adjustment}_{\text{casemix}}$ $= (0.9985)(\$981.91) = \980.48 .

[0063] By dealing with the Total Average Covered Charge or TACClessRx, the program automatically adjusts for changes in the number of PTE's from the budget year and the performance year. The cost budget is preferably also adjusted for inflation/deflation. This can be done in any number of ways including through consumer price index, actual cost increase/decrease, etc. The adjusted budget cost is then compared to the actual costs, and if there is a net cost savings the group will be entitled to share in the savings provided that the group also

met at a minimum Level I quality standards. If the actual performance of a group is below its budget, after that budget is adjusted for changes in case severity and inflation, and the group achieves at least the Level I quality goal, then the group is entitled to share in the cost saving, if any. The share is determined by two factors: whether the group is above or below the network's mean TACClessRx, and the measure of quality (Level I, Level II, or intermediate).

[0064] In comparing the group's TACClessRx with the network TACClessRx, it is desirable to adjust the network TACClessRx to the groups actual case mix. This can be accomplished according to the following formula: Adjusted Network TACClessRx = ((Group Casemix) / (Network Casmix)) (Network TACClessRx).

[0065] In one example, being below budget but above the network mean TACClessRx entitles the group to a 35% share in the cost savings and being below budget and below the Adjusted Network mean TACClessRx entitles the group to a 45% share in the cost savings. Meeting Level I quality goal entitles the group to an additional 9% share, meeting Level II quality goal entitles the group to an additional 15% share, and achieving greater than Level I but less than Level II entitles the group to an additional 12% share. In reality, since at least Level I quality goals must be met to qualify for savings sharing, the minimum share is 44% (35% plus 9%). Table 5 shows the cost savings shares:

	Group's TACClessRx higher than Adjusted Network mean TACClessRx	Group's TACClessRx lower than Adjusted Network mean TACClessRx
Achieve Level I quality goal	44% (35% + 9%)	54% (45% + 12%)
Achieve greater than Level I quality goal but less than Level II quality goal	47% (35% + 12%)	57% (45% + 12%)
Achieve Level II quality goal	50% (35% + 15%)	60% (45% + 15%)

Example 4

[0066] A physicians group had a budget of 2,330 PTE's and a Casemix_{budget year} of 1.154, and a total average covered charge TACClessRx_{budget year} of \$1350. The physicians group had an actual performance of 2,250 PTE's, a Casemix_{performance year} of 1.371, and a total average covered

charge TACClessRx_{performance year} of \$1,440. The casemix-adjusted TACClessRx_{budget} is \$1604. Thus, although the actual TACClessRx_{performance year} was higher than TACClessRx_{budget year}, the adjusted TACClessRx_{budget year} was higher than the TACClessRx_{performance year}, so that there was an actual savings of \$164. This means that there is a total savings of 2250 PTE's x \$164/PTE = \$369,000. If the group's TACClessRx_{performance year} of \$1440 is below the network mean, and the group met Level I quality targets, the group is entitled to performance-based additional compensation of 54% (45% + 9%) of the \$369,000 savings or \$199,260.

[0067] Reporting is an important part of the program to enable the groups, and the individual physicians in the groups to adjust their practices to provide appropriate patient care. Samples of some of the reports that provide useful feed back to the groups, the individual physicians, and the plan administrators are:

[0068] The Program Specialist Group PTE Profile with Network Comparison. This report, a sample of which is shown in Fig. 3, ranks PTE Descriptions comparing the group against the network, showing PTE equivalents, casemix, TACC, and TACClessRx. This report provides the group with a comparison to the applicable specialty network including, whether the network experience is similar to the group's highest number of PTE's, the group's casemix vs. the network's casemix, and the group's TACC-Rx versus the network's TACC-Rx. This information helps the group to know the PTE's on which to focus.

[0069] Program Specialist Physician PTE Cost Categories Report. This report, a sample of which is shown in Fig. 5, compares, for the top three PTE descriptions, the physician's costs to both the group and network totals, per PTE description. The report shows TACC broken out as professional, Facility other and drug charges with further break outs within the first three subcategories for the period. This report allows comparison by individual physicians for a specified PTE, to the group and to the network for a breakdown of charge within specific categories.

[0070] PTE Detail Utilization – Inpatient report. This report, a sample of which is shown in Fig. 6, lists physicians for the top ten PTE descriptions, comparing the group against the network. The report shows PTE equivalents, casemix, TACC and breaks out TACC as professional, facility, other, and outpatient drug charges for the period. The report also shows inpatient admits per PTE equivalent and average coverage charge per admit for the period. For

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[0081] The Medical Cost Trend Comparison report. This report, a sample of which is shown in Fig. 18, compares the rate of change for a Program group, from the prior to the current year, to the non-PGPP applicable medical specialty network change for the same time period.

